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| |  | | --- | | **Authority Letter**  Medical Treatment |  |  | | --- | | To  [Receiver Name]  [Receiver Title]  [Addess]  [Email] | |  | | From  [Sender Name]  [Sender Title]  [Addess]  [Email] | | |  | | --- | |  | |  | | **Subject:** Authorization for Minor's Medical Treatment  Dear [Recipient's Name],  I, [Your Full Name], am the legal parent/guardian of [Minor's Full Name], born on [Date of Birth], and I hereby authorize [Agent's Full Name], to act as my authorized agent to make medical decisions and provide consent for any necessary medical treatment on behalf of my minor child.  **In my absence or unavailability due to unforeseen circumstances, [Agent's Full Name] is empowered to:**   1. Seek medical treatment and make decisions regarding medical procedures, surgeries, or any other medical interventions required for the well-being of my minor child. 2. Provide medical history and information about the minor child to healthcare professionals. 3. Sign any necessary medical consent forms and other related documents on my behalf.   This authorization is valid from [Start Date] to [End Date], unless revoked earlier in writing by me.  I understand that this authorization is given voluntarily, and I trust [Agent's Full Name] to make decisions in the best interest of my minor child's health and well-being.  I will do my best to remain reachable and provide any necessary information, but I acknowledge and accept that [Agent's Full Name]has the authority to make medical decisions in my absence.  Please feel free to contact me at [Your Phone Number] or [Your Email Address] for any questions or clarifications.  Thank you for your understanding and cooperation in this matter.  Sincerely,  [Your Signature]  [Your Full Name] | |